Imperial County Schools Voluntary Employees Benefits Association

Plan Document and Summary Plan Description

Medical and Prescription Drug Benefits

Participating Employers

Calipatria Unified School District
El Centro Elementary School District
Heber Elementary School District
Imperial County Office of Education
Imperial Valley College
Imperial Valley ROP
Magnolia School District
McCabe Union School District
Meadows UnionSchool District
Mulberry School [1]District
San Pasqual Valley Unified School District
Seeley Union School District

The benefits described in this PDSPD, based on a Benefit Year of October 1 – September 30, are part of the Welfare Benefit Plan for Employees of Imperial County Schools Voluntary Employees Benefits Association

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document), made by Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA), (the "Plan Sponsor") as of January 1, 2022, hereby amends and restates Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA) (the "Plan"), which was originally adopted by the Company, effective October 1,1997.

Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA)

By: Stacey Arthur Juan Cruz

Name: Stacey Arthur Juan Cruz

Date: 08/24/2022 17:18 UTC
08/24/2022 22:38 UTC

Title: ICSVEBA, Chair ICSVEBA CO-Chair

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a Non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for medical and prescription drug benefits. The Plan Document is maintained by the Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA) and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Name of Plan:	**Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA)**
Plan Sponsor:	**Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA) 701 McCabe Road El Centro, CA 92243 Phone: (760) 335-5200 Fax: (760) 352-4398 Email: www.icsveba.org**
Plan Administrator: (Named Fiduciary)	**Imperial County Schools Voluntary Employees Benefits Association (ICSVEBA) 701 McCabe Road El Centro, CA 92243 Phone: (760) 335-5200 Fax: (760) 352-4398 Email: www.icsveba.org**
Plan Sponsor ID No. (EIN):	**33-6300113**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**Federal**
Plan Year:	**October 1 through September 30**

Plan Type:	**Medical** **Prescription Drug**
Contract Administrator:	**Delta Health Systems** **3244 Brookside Road, Suite 200** **Stockton, CA 95219** **Phone: 1-800-422-6099** **Fax: 209-474-5407** **Email/Website: www.deltahealthsystems.com**
Participating Districts:	**Calipatria Unified School District** **El Centro Elementary School District** **Heber Elementary School District** **Imperial County Office of Education** **Imperial Valley College** **Imperial Valley ROP** **Magnolia School District** **McCabe Union School District** **Meadows Union School District** **Mulberry School District** **San Pasqual Valley Unified School District** **Seeley Union School District**
Agent for Service of Process:	**Delta Health Systems** **3244 Brookside Road, Suite 200** **Stockton, CA 95219** **Phone: 1-800-422-6099** **Fax: 209-474-5407** **Email/Website: www.deltahealthsystems.com**

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health

and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Non-Discrimination

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participants' rights; and to determine all questions of fact and law arising under the Plan.

ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage
Each full-time Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself following completion of a Service Waiting Period, if applicable, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Please see the Participating Districts section below for each participating district's eligibility requirements.

If you become eligible on the 1st day of the month; coverage is effective on that day IF you complete and return the enrollment form within 31 days of your hire date. If you become eligible on any date AFTER the 1st of the month, coverage is effective on the 1st day of the calendar month AFTER you become eligible IF you complete and return the enrollment form within 31 days of your hire date.

Participating Districts
To be eligible to enroll as an Employee or a Retiree, an individual must meet the requirements outlined below (based upon the employer you receive benefits through):

Calipatria Unified School District

1. A regular employee who is working on a full-time or part-time basis as a Management, Certificated or Classified employee, or a member of the Board of Trustees.

    a. A full-time employee is one working at least 7 hours/day.
    b. A part-time employee is one working at least 4 hours but less than 7 hours/day.
    c. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. A retiree who is at least 55 years of age, with a minimum of 10 years of continuous service with the District and who retired through the Public Employees' Retirement System (PERS) or through the State Teachers' Retirement System (STRS).

3. A former member of the Board of Trustees, pursuant to Government Code 53201, who satisfies all of the following conditions: (1) served in office after January 1 1981, (2) whose term began before January 1, 1995, and (3) who served for 12 or more years.

El Centro Elementary School District

1. A regular employee who is working on a full-time or part-time basis as a Management (Certificated and Classified) employee, a Classified employee (including but not limited to confidential), or a member of the Board of Trustees.

    a. A full-time employee is one working at least 40 hours/week.
    b. A part-time employee is one working at least 20 hours but less than 40 hours/week.
    c. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. A retiree who is:

    a. A Classified employee or Classified Management employee who is at least 55 years of age, with a minimum of 10 years of continuous service with the District and who retired through the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS), or
    b. A Management (Certificated and Classified) employee who retired through the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS).

Heber Elementary School District

1. A regular employee who is working on a full-time or part-time basis as a Management, Certificated or Classified employee, or a member of the Board of Education.

    a. A full-time employee is one working at least 40 hours/week.
    b. A part-time employee is one working at least 30 hours/week and at least 6 hours/day.
    c. Regular employee" means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. There is no retiree coverage.

Imperial County Office of Education (ICOE)

1. A regular employee who is working on a full-time or part-time basis, or a member of the Board of Education.

    a. A full-time employee is one working at 12 months/year.
    b. A part-time employee is one working at least 10 months but less than 12 months/year.
    c. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. A retiree who:

    a. Was a full-time Certificated employee (75-100%) at the time of retirement, is at least age 55 but less than 65 and: (1) was continuously employed by ICOE for 15 years prior to retirement, or (2) whose age plus years of service totals 70 or more. However, in no case shall a retiree be eligible for benefits without serving a minimum of 10 years of service for ICOE. Eligibility hereunder will extend to the retiree and eligible Dependent(s) but eligibility will not extend beyond the date the retiree attains age 65;
    b. Is a Classified employee who has completed 15 years of service and is receiving a pension according to the rules and regulations of the Employer's pension benefits program at the time of the retirement; or
    c. Is full-time Cabinet level, including the County Superintendent of Schools at the time of retirement at age 55 or older who has been employed by the Imperial County Office of Education, or has been employed at least 15 years as a California Public School Administrator at a school district or school site level or at any other County Office of Education including a minimum of 3 years employed by the Imperial County Office of Education at the Cabinet level.

Imperial Valley College

1. A regular employee who is working on a full-time or part-time basis, or a member of the Imperial Community College District.
    a. A full-time employee is one working at 12 months/year.
    b. A part-time employee is one working at least 10 months but less than 12 months/year.
    c. Regular employee means the individual is scheduled to work for the Employer for at least

the minimum number of months/year for classification as a regular employee.

2. For additional information about retiree coverage, contact your local Human Resources Department.

Imperial Valley ROP

1. A regular employee who is working on a full-time or part-time basis.

    a. A full-time employee is one working at least 30 hours/week.
    b. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. There is no retiree coverage.

Magnolia School District

1. Hired **before July 1, 2005:** Magnolia School District pays the full cost of family coverage for the following employees:

    a. Full-time certified staff member is defined as having a contract for 7 hours/day for at least 183 days.
    b. Full-time classified instructional staff is defined as working at least 35 hours/week for 10 months.

2. Hired **after July 1, 2005:** Magnolia School District pays the full cost of Employee Only coverage for the following employees (*note: family coverage is available, at the employees cost*):

    a. Full-time classified non-instructional staff member is defined as working at least 40 hours/week for 12 months.
    b. Part-time certified staff includes any certified staff that does not have a contract for at least 7 hours/day for at least 183 days.
    c. Part-time classified staff includes any staff that does not meet the above definition for full-time status.
    d. Regular Employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

3. There is no retiree coverage.

McCabe Union School District

1. A regular employee who is working on a full-time basis or a member of the Board of Education.

    a. A full-time employee is one working at least 35 hours/week.
    b. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. A retired Confidential Employee who:

    a. Retires before age 65; and
    b. Has at least twelve (12) years of service; and
    c. Whose age, when added to the length of service in the District totals at least 75.

3. A retired Superintendent who retired prior to October 1, 1993.

Meadows Union School District

1. A regular employee who is working on a full-time basis as a Management, Certificated or Classified employee or on a part-time basis as a Classified employee.

    a. A full-time employee is one working at least 30 hours/week.
    b. A part-time employee is one working at least 5 hours but less than 6 hours/day.
    c. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. A retiree who is a:

    a. Non-Certificated (Classified) employee at least 55 years of age, with a minimum of 10 years of continuous service with the District and who retired through the Public Employees' Retirement Systems (PERS); or
    b. Certificated employee who is at least 55 years of age, with a minimum of 15 years of service with the District, or a Certificated employee who is at least 60 years of age, with a minimum of 10 years of service with the District, and who is retired though the State Teachers' Retirement System (STRS); or
    c. Management (Certificated and Classified) employee who retired through the State Teachers' Retirement System (STRS) or the Public Employees' Retirement System (PERS).

Mulberry School District

1. A regular employee who is working on a full-time basis.

    a. A full-time employee is one working at least 30 hours/week.
    b. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. An employee who is hired as the Superintendent/Principal.

3. A retired Certificated or Classified employee who:

    a. Retires before age 65 and was a full-time employee prior to retirement; or
    b. Has at least twelve (12) years of service with the District and whose age, when added to the length of service in the District, totals at least 75.

San Pasqual Valley Unified School District

1. A regular employee who is:

    a. Working on a full-time basis as a Management, Certificated or Classified employee, or
    b. Any part-time employee working greater than four hours/day and a minimum of 181 days/year.

2. A retiree who is receiving a pension according to the rules and regulations of the Employer's pension benefits program at the time of the retirement.

Seeley Union School District

1. A regular employee who is working on a full-time basis, a member of the Board of Education, and any part-time Certificated employee who is not a member of the certificated bargaining unit, who works less than a 7-hour day, and who has been specifically approved to receive benefits by the

Board of Trustees through either policy or action.

a. A full-time employee is one working at least 6 hours/day.
b. Regular employee means the individual is scheduled to work for the Employer for at least the minimum number of months/year for classification as a regular employee.

2. A retiree who is:

a. Certificated employee with a minimum of 15 years of continuous service and is receiving a pension according to the rules and regulations of the Employer's pension benefits program at the time of the retirement; or
b. Classified employee who has completed 25 year of service and is receiving a pension according to the rules and regulations of the Employer's pension benefits program at the time of retirement.

Active Employment
An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the *General Plan Information* section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

Medicare
You and/or your dependent are **eligible** for Medicare:

1. At age 65 or older if a citizen or permanent resident of the United States, or
2. Younger than age 65 if:

a. Deemed permanently disabled and have been receiving Social Security or Rail Road Retirement Board disability benefits for 24 months, or
b. Diagnosed with End Stage Renal Disease.

Medicare Benefits
You are entitled to the following two types of Medicare benefits:

1. **Part A – Hospital Insurance**: There is no premium for those that are eligible for Medicare. Benefits include:

a. Hospitalization;
b. Skilled nursing care;
c. Home health care; and
d. Hospice.

2. **Part B – Supplementary Medical Insurance:** There is a premium for those that qualify; the amount is deducted from Social Security Checks for those that choose to enroll. Benefits include:

a. Physician charges;
b. Physical and speech therapy;
c. Diagnostic tests;
d. Durable medical equipment;
and e. Outpatient care.

Enrollment

Individuals close to age 65 need to apply for Part A and Part B, unless he/she is already receiving Social Security or Railroad Retirement benefits. The initial enrollment period runs from the three (3) months prior to the 65th birthday until four months after the 65th birthday (a total of 7 months). If you do not enroll during that time, there is a general enrollment period from January 1 – March 31 each year; with the following effective dates:

1. **Part A** is effective immediately upon enrollment.
2. **Part B** is effective July 1 (the beginning of the Medicare Plan year). *Note: A 10% penalty applies on the Part B premium for each year a person could have enrolled but did not.*

Eligibility Dates for Dependent Coverage
Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

Effective Dates of Coverage; Conditions
The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within the thirty-one (31) day period following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.

2. Birth of Dependent Child. If a Dependent Child is born after the date the Employee's coverage for himself or herself under the Plan becomes effective and the Employee has coverage under this Plan for his or her Dependents, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to Pre-Existing Conditions or congenital defects shall not apply to such Child. Such coverage shall continue commencing on the date of birth. In order to continue such coverage, the Employee must make written application to the Plan for such Child and agree to make any required contribution within 60 days from the dependent child's date of birth.

3. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within thirty-one (31) days (60 days for a newborn child) of the date of the newly acquired Dependent's eligibility, and any required contributions are also to be made if enrollment is otherwise approved by the Plan Administrator.

4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.

5. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

6. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

Special and Open Enrollment
Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail within the Eligibility for Coverage section.

Loss of Other Coverage
This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available.
    d. The Plan is no longer offering benefits to a class of similarly situated individuals.
    e. The benefit package option is no longer being offered and no substitute is available.
    f. The Employer contributions were terminated.

Special enrollment rights will not be available to an Employee or Dependent if either of the following occurs:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage.
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within thirty-one (31) days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

New Dependent
An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than thirty-one (31) days (60 days for a newborn child) after he or she acquires the new Dependent. For example, if the Employee is married on September 15, he or she must notify the Plan Administrator and apply for coverage by close of business on October 15.

The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. The Employee has acquired a new Dependent through marriage, legal guardianship, a foster child being placed with the Employee, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) enrolled during the Special Enrollment Period will be effective at 12:01 A.M.:

1. In the case of marriage, on the first day of the calendar month following enrollment;
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a foster child being placed with the Employee, on the date on which such Child is placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.
4. In the case of a Dependent's birth, as of the date of birth.
5. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within sixty (60) days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

Open Enrollment
Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on October 1st, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the month of September in each Plan Year.

Qualified Medical Child Support Orders
This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued,

then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan.
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
   a. Be in writing.
   b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
   c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, and computing premiums or contributions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require

genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

SUMMARY OF BENEFITS

General Limits
Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out of pocket Deductible has been satisfied. Benefits for Pregnancy expenses, which are covered for Employee and Spouse only, are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. "Utilization Management" includes Hospital pre-admission certification, continued stay review, length of stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

Network and Non-Network Provider Arrangement
The Plan contracts with the medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

    a. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as 50 miles radius of a covered person's residence, or if a covered person requires services that are only available from an out-of-network provider, then such out-of-network care will be covered at the network benefit levels; and
    b. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Choice of Providers
The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Plan Administrator, Employer or Contract Administrator. The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Preferred Provider Information
This Plan contains provisions under which a Participant may receive more benefits by using certain

Providers. These Providers are individuals and entities that have contracted with the Plan to provide services to Participants at pre-negotiated rates. The PPO Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO Network Provider.

A current list of PPO Providers is available, without charge, through the Contract Administrator's website (located at www.deltahealthsystems.com). If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Relations Department. The PPO Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a PPO Network Provider before receiving services. Please refer to the Participant identification card for the PPO website address.

Balance Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

Continuity of Care

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner, but in no event later than 7 calendar days after termination that the Provider's contractual relationship with the Plan has terminated, and that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2) is undergoing a course of institutional or Inpatient care from a specific Provider,
3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

No Surprises Act – Emergency Services and Surprise Bills
For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

SUMMARY OF MEDICAL BENEFITS- COMPREHENSIVE MEDICAL PLAN

Comprehensive Medical Plan
The following Calendar Year maximums apply to each Participant.

	Network	Non-Network
Deductible • Individual • Family Unit Covered expenses applied to your in-network deductible do not count toward your out-of-network deductible and vice versa.	 $650 $1,950	 $1,500 $4,500
Payment Level (unless otherwise stated)	80%	50%
Maximum Out-of-Pocket[2] • Individual • Family Unit (embedded) Covered expenses applied to your in-network out-of-pocket maximum do not apply to your out-of-network out-of-pocket maximum and vice versa.	 $3,000 $9,000	 $9,000 $27,000

Covered Medical Expenses:	Network	Non-Network	Limits[3]
1. Allergy Services • Physician Office Visit • Specialist Office Visit • Injections	 $10 co-pay† $20 co-pay† $0†	 50%	
2. Ambulance	80%	80%	
Air ambulance transport from Reach Air Medical will be covered at 100%, not subject to deductible, to a maximum benefit per trip of $12,000. Air ambulance transport from other air ambulance providers is subject to the deductible and covered at 80% to a maximum benefit per trip of $19,000.			
3. Ambulatory Surgical Center	80%	50%	
4. Anesthesia	80%	50%	
5. Birthing Center	80%	50%	
6. Blood & Plasma	80%	50%	
7. Chiropractic Care and Acupuncture	$20 co-pay†	50%	Combined calendar year maximum of $1,500. Does not apply to related diagnostic services.
8. Colonoscopy (either preventive or diagnostic)	100%†	50%	

[2] Excludes amounts over Usual and Customary fees.
[3] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[4]
9. Durable Medical Equipment	80%†	50%	
10. Glaucoma, Cataract Surgery and Lenses (one set)	80%	50%	
11. Hearing Exams and Hearing Aids • Hearing Exams & Tests, per visit • Hearing Aids (limited to $600 per ear, per 60-month period)	$10 co-pay† (PCP) $20 co-pay† (Specialist) 50%	50% 50%	
12. Home Health Care	80%	50%	Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.
13. Hospice Care • Inpatient • Outpatient • Family Bereavement Counseling	80%	50%	Care is limited to 6 months after the date it begins. Inpatient respite care is limited to 8 days per lifetime. Benefit for pre-death and bereavement counseling is limited to $200. Bereavement counseling is limited to services provided within 12 months after the covered person dies.
14. Hospital • Inpatient Treatment • Outpatient Treatment	$250 co-pay per admission, then 80% 80%	$250 co-pay per admission, then 50% 50%	
15. Impregnation and Infertility Treatment	Not covered	Not covered	

[4] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[5]
16. Newborn Care • Hospital • Physician	$250 co-pay per admission, then 80% 80%	$250 co-pay per admission, then 50% 50%	Normal newborn nursery charges are covered under the mother (if the mother is a covered person) for the first fourteen days. No co-pay applies
17. Outpatient Diagnostic X-ray and Lab	100%†	50%	
18. Outpatient Emergency Services – Emergency Room • Emergency	$250 co-pay per incident, then 100%†	$250 co-pay per incident, then 100%†	Co-pay is waived if admitted
19. Outpatient Emergency Services – Other Providers	100%†	100%†	
20. Physician Services • Primary Care Physician, per Visit • Specialist, per Visit • Lab, X-rays and Surgery	$10 co-pay† $20 co-pay† 100%†	50%	Other Practitioner – These services include consultations, hearing exams/tests, rehabilitation, home visits, 2nd opinion and office surgery as well.
21. Pregnancy Expenses (pre-natal care)	80%	50%	
22. Preventive Care	100%†	50%	
23. Private Duty Nursing	80%	50%	Maximum payable is $125 per day. Services must be in lieu of an inpatient hospital ***stay or to avoid a hospital or skilled nursing facility stay.***
24. Prosthetics, Functional Orthotics, Supplies and Surgical Dressings • Foot Orthotics	80% 100%†	50% 50%	Foot Orthotics are limited to $2,000 per calendar year

[5] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[6]
25. Psychiatric Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
26. Skilled Nursing Facility	80%	$500 Co-pay, then 50%	Allowed 90 days per calendar year. Both the deductible & the copay apply to non-PPO providers. Inpatient copays will be applied first, then any amount needed to meet the annual deductible then the balance of the charges will be paid at the coinsurance percentage listed
27. Substance Abuse Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
28. Surgery	80%	50%	
29. Temporomandibular Joint Disorder (TMJ)	Payable under services rendered	50%	

[6] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

30. Therapy • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	$10 co-pay† $10 co-pay† 80% $10 co-pay†	50%	Benefits shown below is for outpatient services. If services are performed on an inpatient basis, benefits will be at the same percent as other inpatient hospital services.
31. Transplants	Payable under services rendered		
32. Urgent Care Facility	$10 co-pay†	$10 co-pay†	
33. Telemedicine	100%†	Not covered	
34. All Other Covered Services	80%	50%	

SUMMARY OF MEDICAL BENEFITS- BASIC MEDICAL PLAN

Basic Medical Plan
The following benefits are per Participant per Calendar Year:

	Network	Non-Network
Deductible • Individual • Family Unit Covered expenses applied to your in-network deductible do not count toward your out-of-network deductible and vice versa.	 $1,500 $4,500	 $3,000 $9,000
Payment Level (unless otherwise stated)	80%	50%
Maximum Out-of-Pocket[7] • Individual • Family Unit (embedded) Covered expenses applied to your in-network out-of-pocket maximum do not apply to your out-of-network out-of-pocket maximum and vice versa.	 $6,600 $13,200	 $10,000 $30,000

Covered Medical Expenses:	Network	Non-Network	Limits
1. Allergy Services • Office Visit • Injections • Serum	 $35 co-pay† (PCP) $70 co-pay† (specialist) $0† $0†	50%	
2. Ambulance	80%	80%	
Air ambulance transport from Reach Air Medical will be covered at 100%, not subject to deductible, to a maximum benefit per trip of $12,000. Air ambulance transport from other air ambulance providers is subject to the deductible and covered at 80% to a maximum benefit per trip of $19,000.			
3. Ambulatory Surgical Center	80%	50%	
4. Anesthesia	80%	50%	
5. Birthing Center	80%	50%	
6. Blood & Plasma	80%	50%	
7. Chiropractic Care and Acupuncture	$30 co-pay†	50%	Combined calendar year maximum of $1,500. Does not apply to related diagnostic services.

[7] Excludes amounts over Usual and Customary fees.
[8] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

8. Colonoscopy (either preventive or diagnostic)	100%†	50%	
Covered Medical Expenses:	**Network**	**Non-Network**	**Limits**
9. Durable Medical Equipment	100%†	50%	
10. Glaucoma, Cataract Surgery and Lenses (one set)	80%	50%	
11. Hearing Exams and Hearing Aids □ Hearing Exams & Tests, per visit □ Hearing Aids	 $35 co-pay† (PCP)/$70 co-pay† (Specialist) 50%	 50% 50%	 Limited to $600 per ear, per 60-month period
12. Home Health Care	80%	50%	Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.
13. Hospice Care • Inpatient • Outpatient • Family Bereavement Counseling	80%	50%	Care is limited to 6 months after the date it begins. Inpatient respite care is limited to 8 days per lifetime. Benefit for pre-death and bereavement counseling is limited to $200. Bereavement counseling is limited to services provided within 12 months after the covered person dies.

[9] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[10]
14. Hospital • Inpatient Treatment • Outpatient Treatment	$250 co-pay per admission, then 80% 80%	$250 co-pay per admission, then 50% 50%	Inpatient copays will be applied first, then any amount needed to meet the annual deductible then the balance will be paid at the coinsurance percentage listed.
15. Impregnation and Infertility Treatment	Not covered	Not covered	
16. Newborn Care • Hospital • Physician	$250 co-pay per admission, then 80% 80%	$250 co-pay per admission, then 50% 50%	Normal newborn nursery charges are covered under the mother (if the mother is a covered person) for the first fourteen days. No co-pay applies.
17. Outpatient Diagnostic X-ray and Lab	80%	50%	
18. Outpatient Emergency Services – Emergency Room • Emergency	$250 co-pay per incident, then100%†	$250 co-pay per incident, then 100%†	Co-pay is waived if admitted
19. Outpatient Emergency Services – Other Providers	100%†	100%†	
20. Physician Services • Primary Care Physician, per Visit • Specialist, per Visit • Lab, X-rays and Surgery	 $35 co-pay† $70 co-pay† 100%†	50%	
21. Pregnancy Expenses (pre-natal care)	80%	50%	
22. Preventive Care	100%†	50%	
23. Private Duty Nursing	80%	50%	Maximum payable is $125 per day. Services must be in lieu of an inpatient hospital stay or to avoid a hospital or skilled nursing facility stay.

[10] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.

† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[11]
24. Prosthetics, Functional Orthotics, Supplies and Surgical Dressings • Foot Orthotics	80% 100%†	50% 50%	Foot Orthotics are limited to $2,000 per calendar year
25. Psychiatric Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
26. Skilled Nursing Facility	80%	$500 co-pay, then 50%	Maximum of 90 days per confinement. Both the deductible & the copay applies to non-PPO providers. Inpatient copays will be applied first, then any amount needed to meet the annual deductible then the balance of the charges will be paid at the coinsurance percentage listed.
27. Substance Abuse Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
28. Surgery	80%	50%	
29. Temporomandibular Joint Disorder (TMJ)	Payable under services rendered	50%	

[11] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.

† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[12]
30. Therapy • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	 $15 co-pay† $15 co-pay† 80% $15 co-pay†	50%	Benefit shown is for outpatient services. If services are performed on an inpatient basis, benefits will be at the same percent as other inpatient hospital services.
31. Transplants	Payable under services rendered		
32. Urgent Care Facility	$30 co-pay†	$30 co-pay†	
33. Telemedicine	100%†	Not covered	
34. All Other Covered Services	80%	50%	

[12] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

SUMMARY OF MEDICAL BENEFITS- COORDINATION OF BENEFITS (COB) MEDICAL PLAN

Coordination of Benefits (COB) Plan
The following Calendar Year maximums apply to each Participant.

	Network	Non-Network
Deductible • Individual • Family Unit	 None None	 None None
Payment Level (unless otherwise stated)	30%	30%
Maximum Out-of-Pocket[13] • Individual • Family Unit	 None None	 None None

Covered Medical Expenses:	Network	Non-Network	Limits[14]
1. Allergy Services • Office Visit • Injections • Serum	30%	30%	
2. Ambulance	30%	30%	Air ambulance transport from Reach Air Medical: $12,000 per trip Air ambulance from other air ambulance providers: $19,000 per trip
3. Ambulatory Surgical Center	30%	30%	
4. Anesthesia	30%	30%	
5. Birthing Center	30%	30%	
6. Blood & Plasma	30%	30%	
7. Chiropractic Care and Acupuncture	30%	30%	Combined calendar year maximum of $1,500. Does not apply to related diagnostic services.

[13] Excludes amounts over Usual and Customary fees.
[14] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[15]
8. Durable Medical Equipment	30%	30%	
9. Glaucoma, Cataract Surgery and Lenses (one set)	30%	30%	
10. Hearing Exams and Hearing Aids • Hearing Aids (limited to $600 per ear, per 60-month period)	30%	30%	
11. Home Health Care	30%	30%	Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.
12. Hospice Care • Inpatient • Outpatient • Family Bereavement Counseling	30%	30%	Care is limited to 6 months after the date it begins. Inpatient respite care is limited to 8 days per lifetime. Benefit for pre-death and bereavement counseling is limited to $200. Bereavement counseling is limited to services provided within 12 months after the covered person dies.
13. Hospital • Inpatient Treatment • Outpatient Treatment	30%	30%	
14. Impregnation and Infertility Treatment	Not covered	Not covered	
15. Newborn Care • Hospital • Physician	30%	30%	Normal newborn nursery charges are covered under the mother (if the mother is a covered person) for the first fourteen days. No co-pay applies.
16. Outpatient Diagnostic X-ray and Lab	30%	30%	

[15] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.

† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[16]
17. Outpatient Emergency Services – Emergency Room • Emergency	30%†	30%†	
18. Outpatient Emergency Services – Other Providers	30%	30%	
19. Physician Services • Primary Care Physician, per Visit • Specialist, per Visit • Lab, x-rays and Surgery	30%	30%	
20. Pregnancy Expenses (pre-natal care)	30%	30%	
21. Preventive Care	100%†	30%	
22. Private Duty Nursing	30%	30%	Maximum payable is $125 per day. Services must be in lieu of an inpatient hospital stay or to avoid a hospital or skilled nursing facility stay.
23. Prosthetics, Functional Orthotics, Supplies and Surgical Dressings • Foot Orthotics	30%	30%	Foot Orthotics are limited to $2,000 per calendar year
24. Psychiatric Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
25. Skilled Nursing Facility	30%	30%	Covered is limited to 90 days per confinement

[16] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.

† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[17]
26. Substance Abuse Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
27. Surgery	30%	30%	
28. Temporomandibular Joint Disorder (TMJ)	Payable under services rendered	30%	
29. Therapy • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	30%	30%	
30. Telemedicine	100%†	Not covered	
31. Transplants	Payable under services rendered		
32. All Other Covered Services	30%	30%	

[17] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

SUMMARY OF MEDICAL BENEFITS- BRONZE MEDICAL PLAN

Bronze Medical Plan
The following benefits are per Participant per Calendar Year:

	Network	Non-Network
Deductible • Individual • Family Unit Covered expenses applied to your in-network deductible do not count toward your out-of-network deductible and vice versa.	 $5,000 $10,000	 $15,000 $30,000
Payment Level (unless otherwise stated)		
Maximum Out-of-Pocket[18] • Individual • Family Unit (embedded) Covered expenses applied to your in-network out-of-pocket maximum do not apply to your out-of-network out-of-pocket maximum and vice versa.	 $6,350 $12,700	 $25,000 $50,000

Covered Medical Expenses:	Network	Non-	Limits[19]
1. Allergy Services • Office Visit • Injections • Serum	 70% 70% 70%	 50%	
2. Ambulance	70%	50%	
Air ambulance transport from Reach Air Medical will be covered at 100%, not subject to deductible, to a maximum benefit per trip of $12,000. Air ambulance transport from other air ambulance providers is subject to the deductible and covered at 80% to a maximum benefit per trip of $19,000.			
3. Ambulatory Surgical Center	70%	50%	$600 maximum benefit allowed per day for Non-Network
4. Anesthesia	70%	50%	
5. Birthing Center	70%	50%	
6. Blood & Plasma	70%	50%	
7. Chiropractic Care and Acupuncture	70%	50%	Combined calendar year maximum of $1,500. Does not apply to related diagnostic services.
8. Colonoscopy (either preventive or diagnostic)	100%†	50%	

[18] Excludes amounts over Usual and Customary fees.
[19] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[20]
9. Durable Medical Equipment	70%	50%	
10. Glaucoma, Cataract Surgery and Lenses (one set)	70%	50%	
11. Hearing Exams and Hearing Aids • Hearing Exams & Tests, per visit • Hearing Aids	 70% 70%	 50% 50%	Limited to $600 per ear, per 60-month period.
12. Home Health Care	70%	50%	Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.
13. Hospice Care • Inpatient • Outpatient • Family Bereavement Counseling	70%	50%	Care is limited to 6 months after the date it begins. Inpatient respite care is limited to 8 days per lifetime. Benefit for pre- death and bereavement counseling is limited to $200. Bereavement counseling is limited to services provided within 12 months after the covered person dies.
14. Hospital • Inpatient Treatment • Outpatient Treatment	 70% 70%	 50% 50%	$600 maximum benefit allowed per day for Non-Network
15. Impregnation and Infertility Treatment	Not covered	Not covered	
16. Newborn Care • Hospital • Physician	 70% 70%	 50% 50%	$600 maximum benefit allowed per day for Non-Network inpatient services. Normal newborn nursery charges are covered under the mother (if the mother is a covered person) for the first fourteen days

[20] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[21]
17. Outpatient Diagnostic X-ray and Lab	70%	50%	
18. Outpatient Emergency Services – Emergency Room • Emergency • Non-Emergency	$100 co-pay per incident, then70%† 70%	$100 co-pay per incident, then 50%† 50%	Co-pay is waived if admitted
19. Outpatient Emergency Services – Other Providers	100%†	100%†	
20. Physician Services • Primary Care Physician, per Visit • Specialist, per Visit • Lab, X-rays and Surgery	70%	50%	
21. Pregnancy Expenses (pre-natal care)	70%	50%	
22. Preventive Care	100%†	Not covered	
23. Private Duty Nursing	70%	50%	Maximum payable is $125 per day. Services must be in lieu of an inpatient hospital stay or to avoid a hospital or skilled nursing facility stay.
24. Prosthetics, Functional Orthotics, Supplies and Surgical Dressings • Foot Orthotics	70% 70%	50% 50%	Foot Orthotics are limited to $2,000 per calendar year
25. Psychiatric Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
26. Skilled Nursing Facility	70%	50%	Covered is limited to 90 days per confinement

[21] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

Covered Medical Expenses:	Network	Non-Network	Limits[22]
27. Substance Abuse Benefits • Inpatient Physician • Outpatient Physician • Partial Day Program • Residential Treatment	No coverage under the medical plan	No coverage under the medical plan	Benefits for Mental/Behavioral Health and Substance use disorders are covered through a separate plan with Beacon. Call 1-866-533-4278.
28. Surgery	70%	50%	
29. Temporomandibular Joint Disorder (TMJ)	Payable under services rendered	50%	
30. Therapy • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	70%	50%	
31. Transplants	Payable under services rendered		
32. Urgent Care Facility	70%	Not covered	
33. Telemedicine	100%†	Not covered	
34. All Other Covered Services	70%	50%	

[22] These limits are in addition to all other Plan exclusion, limitations and provisions set forth in this Plan.
† Deductible waived.

PRESCRIPTION DRUG BENEFITS

Covered Prescription Drug Expenses:	Participating Pharmacy	Non-Participating Pharmacy
Pharmacy Option:		
Co-payment, per prescription or refill, for generic	$5.00	N/A
Co-payment, per prescription or refill, for name brands	$25.00	N/A
Co-payment, per prescription or refill, for non-formulary name brands	$55.00	N/A
Mail Order Option:		
Co-payment, per prescription or refill, for generic	$5.00	N/A
Co-payment, per prescription or refill, for name brands	$25.00	N/A
Co-payment, per prescription or refill, for non-formulary name brands	$55.00	N/A
Specialty Option:		
Co-payment, per prescription or refill	20% at retail and home delivery $1,000 out of pocket maximum for specialty medications only	

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. Express-Scripts is the administrator of the prescription Drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of the volume buying, Express-Scripts, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The copayment is applied to each charge and is shown on the Summary of Benefits, above. The copayment amount is not counted toward any out of pocket maximums under the Plan.

Covered Expenses
The following are covered under the Plan:

1. **Acne Control and Cosmetic Anti-Aging.** Accutane and Retin A. Prior Authorization is required after age 25;

2. **Anorexiants (weight-loss drugs).** Prior Authorization is required;

3. **Bee Sting Kits.** Charges for EPI PEN;

4. **Compounded Prescriptions.** Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity and not containing excluded ingredients;

5. **Contraceptives.** All Food and Drug Administration (FDA)-approved contraceptives Drugs and methods, in accordance with the Health Resources and Services Administration (HRSA) guidelines;

6. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed;

7. **DESI Drugs.** Charges for DESI Drugs;

8. **Diabetes.** Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over the counter, and glucose test strips, when prescribed by a Physician;

9. **Gleevec.** Gleevec, for treatment of any of the following conditions:

    a. CML myeloid blast crisis;
    b. CML accelerated phase; or
    c. CML in chronic phase after failure of interferon treatment;

    Prior authorization is required. In order to obtain such authorization, information from the patient's Physician indicating the condition being treated must be submitted to the Plan.

10. **Growth Hormones;**

11. **Imitrex Injection;**

12. **Immunizations;**

13. **Impotency medication,** including Viagra ™. Yohimbine is excluded;

14. **Injectables.** Injectables, unless otherwise excluded on another line item;

15. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;

16. **Legend Drugs.**

    a. Class V Drugs;
    b. Diabetic Supplies;
    c. Diagnostics;
    d. Pre natal vitamins; and
    e. Vitamins, as required by the Affordable Care Act.

17. **Medical Devices and Supplies.** Charges for legend and over-the-counter medical devices and supplies. Ostomy supplies are excluded;

18. **Non-Insulin Syringes/Needles;**

19. **No Charge.** A Charge for Drugs which may be properly received without charge under local, State or Federal programs;

20. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law;

21. **Over-the-Counter (OTC) Drugs.** OTC Drugs related to Preventive and Wellness Services as specified by the Affordable Care Act of 2010. While a summary of these services can be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/, this is not an all-inclusive list of the OTC Drugs that are covered under these services.

    This includes Food and Drug Administration (FDA)-approved generic Drugs and Over-the-Counter (OTC) Drugs, devices and supplies related to Women's Preventive Services, as specified by the

Affordable Care Act of 2010.
A description of FDA-approved contraceptive methods can be found at: http://www.fda.gov/ForConsumers/ByAudience/ForWomen/WomensHealthTopics/ucm117971.htm.

21. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below;

22. **Smoking Deterrents.** Smoking Deterrents, covered for Plan Participants over age eighteen (18) as required by the Affordable Care Act; and

23. **Steroids.** Steroids (prescription only).

Limitations
The benefits set forth in this Article will be limited to:

1. **Dosages.**

    a. With respect to the Pharmacy Option, any one prescription is limited to the greater of a 30-day supply; and
    b. With respect to the Mail Order Option, any one prescription is limited to the greater of a 90-day supply; and

2. **Refills.**

    a. Refills only up to the number of times specified by a Physician; and
    b. Refills up to one year from the date of order by a Physician.

Exclusions
In addition to the General Exclusions set forth, the following are not covered by the Plan:

1. **Administration.** Any charge for the administration of a covered Drug;

2. **Allergy Sera.** Charges for allergy sera;

3. **Blood and Blood Plasma.** Charges for blood and blood plasma;

4. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;

5. **Excluded Items.** Any charge excluded under the Articles entitled "General Limitations and Exclusions," or "Summary of Benefits";

6. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant;

7. **Fertility Agents.** Charges for fertility agents;

8. **Immunologicals.** Charges for immunologicals (vaccines);

9. **Investigational Use Drugs.** A Drug or medicine labeled "Caution – limited by Federal law to Investigational use";

10. **Legend Drugs.**

    a. Legend Drugs with over the counter equivalents;

11. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin;

12. **Over-the-counter Drugs.** Charges for over the counter Drugs except to the extent required by the Affordable Care Act:

    a. Class V Drugs;
    b. Diagnostics;
    c. Medical devices and supplies
    d. Pre natal vitamins; and
    e. Vitamins;

13. **Rogaine.** Charges for Rogaine (topical minoxidil); and

14. **Vitamins.** Vitamins, except pre-natal vitamins. Over the counter vitamins are not covered except as required by the Affordable Care Act.

MEDICAL BENEFITS

Medical Benefits
Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Abortion.** Expenses Incurred directly or indirectly as the result of an abortion;

2. **Acupuncture.** Charges relating directly or indirectly to acupuncture;

3. **Allergy Services.** Charges related to the Treatment of allergies;

4. **Ambulance.** Transportation by professional ambulance, limited to professional ground ambulance services when used locally to transport a covered person to and from a Hospital or skilled nursing facility, or to transfer a covered person from an out-of-network Hospital to a network Hospital following stabilization of a medical emergency. Professional air ambulance services when necessary to transport a covered person, in a medical Emergency, to the nearest stateside (i.e. U.S.) hospital where necessary treatment can be rendered;

5. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;

6. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;

7. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;

8. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;

9. **Chemotherapy.** Charges for chemotherapy/radiation;

10. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;

11. **Contraceptives.** The charges for all Food and Drug Administration (FDA) approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines. The Plan will also cover contraception-related services, including the initial visit to the prescribing Physician and any follow-up visits or other outpatient services for preventive care;

12. **Dental.** Emergency repair due to Injury to sound natural teeth, if the repair is made within 12 months from the date of the Injury (unless otherwise required by applicable law);

13. **Diagnostic Tests; Examinations.** Charges for x rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;

14. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:

    a. Any purchases without its advance written approval;
    b. Replacements or repairs; or
    c. The rental or purchase of items which do not fully meet the definition of "Durable Medical

Equipment";

15. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);

16. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);

17. **Gleevec.** Gleevec, for treatment of any of the following conditions:

    a. CML myeloid blast crisis;
    b. CML accelerated phase; or
    c. CML in chronic phase after failure of interferon treatment;

    Prior authorization is required. In order to obtain such authorization, information from the patient's Physician indicating the condition being treated must be submitted to the Plan;

18. **Hearing Devices.** Hearing aids or examinations for the prescription or fitting of hearing aids. Limited to $600 per ear every 60 months.

19. **Home Health Care.** Charges by a Home Health Care Agency:

    a. Registered Nurses or Licensed Practical Nurses;
    b. Certified home health aides under the direct supervision of a Registered Nurse;
    c. Registered therapist performing physical, occupational or Speech Therapy;
    d. Physician calls in the office, home, clinic or Outpatient department;
    e. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care; and
    f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

    NOTE: Transportation services are not covered under this benefit. Home health aide services are limited to 20 hours per week. Benefits for nutritional counseling are limited to $50 per Calendar Year.

20. **Hospice Care.** Charges relating to Hospice Care, provided the Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

    a. Room and Board for Confinement in a Hospice;
    b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
    c. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
    d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
    e. Home health aide services;
    f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
    g. Medical social services by licensed or trained social workers, Psychologists or counselors;
    h. Nutrition services provided by a licensed dietitian; and

i. Respite care (inpatient respite care is limited to eight (8) days per lifetime);

Hospice care is limited to care provided within six (6) months of the date hospice care begins. Inpatient respite care is limited to eight (8) days per lifetime. Benefit for pre-death and bereavement counseling is limited to $200. Bereavement counseling is limited to services provided within 12 months after the covered person dies.

21. **Hospital.** Charges made by a Hospital for:

    a. Inpatient Treatment
        i. Daily Semi Private Room and Board charges;
        ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
        iii. General nursing services; and
        iv. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

    b. Outpatient Treatment
        i. Emergency room;
        ii. Treatment for chronic conditions;
        iii. Physical Therapy treatments;
        iv. Hemodialysis; and
        v. X ray, laboratory and linear therapy;

22. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

    As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

    a. Reconstruction of the breast on which the Mastectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;

    in a manner determined in consultation with the attending Physician and the patient.

    This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

23. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics;

24. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse. Newborn care is payable under the Employee/Mother's coverage for the first 14 days. After the first 14 days a child should be properly enrolled in the Plan to receive coverage as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and coinsurance provisions will apply;

a. Hospital routine care for a Newborn during the Child's initial Hospital Confinement at birth; and
b. The following Physician services for well baby care during the Newborn's initial Hospital Confinement at birth:

    i. The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
    ii. Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

25. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;

26. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing Outpatient facility;

27. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;

28. **Orthognathic Surgery.** Orthognathic surgery when Medically Necessary.

29. **Pathology Services.** Charges for Pathology Services;

30. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed Outpatient therapy facility;

31. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations;

32. **Pregnancy Expenses.** Dependent children are eligible for coverage for any expenses in connection with Pregnancy and delivery services. ***NOTE:*** *Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

    Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours). In no event will an "attending Provider" include a plan, Hospital, managed care organization, or other issuer.

    Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums;

33. **Preventive Care.** Charges for Preventive Care services.

    Benefits mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

    See http://www.uspreventiveservicestaskforce.org
    or https://www.healthcare.gov/coverage/preventive-care-benefits/ for more details.

    Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider of care to determine which services to provide;

    Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence- based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

    Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

    With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

    A description of Preventive and Wellness Services can be found at:
    https://www.healthcare.gov/coverage/preventive-care-benefits/

    Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

    a. Well-woman visits;
    b. Gestational diabetes screening;
    c. HPV DNA testing;
    d. Sexually transmitted infection counseling;
    e. HIV screening and counseling;
    f. FDA-approved contraception methods and contraceptive counseling;
    g. Breastfeeding support, supplies and counseling; and
    h. Domestic violence screening and counseling.

    A description of Women's Preventive Services can be found at:
    http://www.hrsa.gov/womensguidelines/
    or at https://www.healthcare.gov/coverage/preventive-care-benefits/.

34. **Private Duty Nursing.** Private duty nursing (outpatient only);

35. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;

36. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;

37. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;

38. **Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

    a. The clinical trial is approved by any of the following:
        i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
        ii. The National Institute of Health.
        iii. The U.S. Food and Drug Administration.
        iv. The U.S. Department of Defense.
        v. The U.S. Department of Veterans Affairs.
        vi. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
    b. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

39. **Second Surgical Opinions.** Charges for second surgical opinions;

40. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding Drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Participant is confined;

41. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;

42. **Sterilization.** All FDA approved charges related to sterilization procedures, to the extent required by the Affordable Care Act (ACA);

43. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
    a. Multiple procedures adding significant time or complexity will be allowed at:
        i. One hundred percent (100%) of the full Usual and Customary Fee value for the first or major procedure;
        ii. Fifty percent (50%) of the Usual and Customary Fee value for the secondary and subsequent procedures;
        iii. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of Usual and Customary Fee value for the major procedure, and fifty percent (50%) of the Usual and Customary Fee value for the secondary or lesser procedure;
    b. Charges made for services rendered by an assistant surgeon will be allowed at twenty-five (25%) of the Usual, and Customary Fee value for the type of Surgery performed;

c. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;

44. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;

45. **Telemedicine.** Charges for the use of interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of a patient from a site other than where the patient is located. Telemedicine services can be furnished by any licensed provider.

46. **Temporomandibular Joint Disorder.** Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders or myofascial pain dysfunction; and

47. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

    a. Bone marrow;
    b. Heart;
    c. Lung;
    d. Heart and lung;
    e. Liver;
    f. Pancreas;
    g. Kidney; and
    h. Cornea.

    In addition, the Plan will cover any other transplant that is not Experimental.

    Covered Expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

    a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
    b. Services and supplies furnished by a Provider; and
    c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

    Surgical, storage and transportation costs, including donor medical expenses. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

MEDICAL EXCLUSIONS

Some health care services are not covered by the Plan. In addition to the General Exclusions section, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Biofeedback.** Biofeedback;

2. **Cochlear Implants**

3. **Consultations.** Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

4. **Cosmetic Surgery.** Charges for Cosmetic Surgery;

5. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or Home Health Care except as specifically provided herein;

6. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

7. **Eye Refractions.** Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury);

8. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness with the exception of hair loss due to cancer treatment;

9. **Hypnosis.** Expenses related to the use of hypnosis;

10. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, surrogate mother, donor eggs;

11. **Nicotine Addiction.** Nicotine withdrawal programs, facilities, Drugs or supplies, except as specified under Preventive Care;

12. **Nutritional Supplements.** Charges for nutritional supplements, except as specified under Preventive Care.

13. **Obesity.** Expenses related to care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity (which is the lesser of 100 pounds over normal weight and twice normal weight). Specifically excluded are charges for bariatric Surgery unless medically necessary, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band Surgery, including reversals. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

14. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;

15. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;

16. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the
    a. cost is included in the orthotist's charge, and other supportive devices for the feet;

17. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;

18. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;

19. **Routine Patient Costs for Participation in an Approved Clinical Trial.**
The following items are excluded from approved clinical trial coverage under this Plan:

    1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
    2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
    3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
    4. A cost associated with managing an Approved Clinical Trial.
    5. The cost of a health care service that is specifically excluded by the Plan.
    6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

    If one or more participating Providers do participate in the Approved Clinical Trial, the qualified plan Participant must participate in the Approved Clinical Trial through a participating, Network Provider, if the Provider will accept the Participant into the trial.

    The Plan does not cover routine patient care services that are provided outside of this Plan's health care Provider Network unless Non-Network benefits are otherwise provided under this Plan.

20. **Routine Physical Examinations.** Routine or periodic physical examinations, related x ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits;

21. **Sex Assignment/Reassignment.** Related to a sex change operation.

22. **Sexual Dysfunction.** For any treatment of a sexual dysfunction, including but not limited to sexual counseling or therapy, implants and hormonal therapy, except of dysfunction due to organic disease or gender dysphoria, unless otherwise specified by the Plan.

23. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein; and

24. **Vitamins.** Vitamins.

COST CONTAINMENT

Services that Require Pre-Certification or Notification
The following services will require pre-certification (or reimbursement from the Plan may be reduced):

1. Inpatient Hospitalization;
2. Transplant Candidacy Evaluation and Transplant (organ and/or tissue);
3. Home Health Services;
4. Durable Medical Equipment (rental greater than 2 months, or purchase in excess of $2,000 billed per date of service);
5. Skilled Nursing Facility stays;
6. Infusion Services;
7. Prescription Specialty Drugs;
8. Inpatient Hospice; and
9. Potentially Cosmetic/Investigative Outpatient Services.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is forty- eight (48) hours or less for a vaginal delivery or ninety-six (96) hours for a cesarean delivery, it is important to have your Physician call to obtain pre-certification in case there is a need to have a longer stay.

Pre-Certification or Notification Procedures and Contact Information
The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll free number, which is 1-800-274-7767. The review process will continue, as outlined below, until the Participant is discharged from the Hospital. Pre-certification is not required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.

Urgent Care or Emergency Admissions:
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within seventy-two (72) hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and

For Emergency admissions on a weekday, a call to the pre-certification department must be made within twenty-four (24) hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-Emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. A system that features widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

The pre-certification department hours of operations are 7:30 a.m. to 5:00 p.m. On weekends and evenings, the Participant can call 1-800-274-7767, and leave a message.

Pre-Certification Penalty
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify pre-certification department of any Inpatient Hospital stay as required in the section entitled "Pre-Certification or Notification Procedures and Contact Information," allowed charges will be reduced by 20% for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

Voluntary: Case Management Program
In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers, care consultants and the hospital staff as necessary.

Case Management will:

1. Evaluate and summarize the patient's continuing medical needs;
2. Assess the quality of current treatments;
3. Coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor;
4. Review the progress of alternative treatment after implementation; and
5. Make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

Important: Case Management is a **voluntary** service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

Delta TeamCare Population Health Management Program
Delta's Population Health Management program can help a Plan participant manage a specific chronic condition through a free, voluntary and confidential program. The program provides a specially trained Disease Management Nurse, via telephone, to assist an enrollee in gaining greater confidence in management of their condition. Disease Management targets:

1. Asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), diabetes, hypertension, congestive heart failure, high cholesterol, stroke and chronic low back pain; and
2. Persons with a chronic condition (as identified through an analysis of health care claims, self-referral or a Physician's recommendation) will be invited to participate in the program.

A Population Health Management Nurse will be assigned to assess the current situation, answer questions,

educate the patient about self-care techniques and assist with lifestyle changes for maximum health and quality of life. On-going telephone counseling and educational materials will increase the patient's understanding of his condition and help him become better at using self-care and improve his overall health. Population Health Management supplements, but does not replace, a person's Physician's care and advice.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

"Accident"
"Accident" shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"Actively At Work" or "Active Employment"
An Employee will be deemed in "Active Employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was Actively At Work on the last preceding regular working day.

An Employee will also be deemed in "Active Employment" on any day on which he is absent from work due to an approved FMLA leave or solely due to his own health status. An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commended Active Employment.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A recession of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"AHA"
"AHA" shall mean the American Hospital Association.

"Allowable Expenses"
"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

"Alternate Recipient"
"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, ,but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

"Approved Clinical Trial"
"Approved Clinical Trial" means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of network benefits are otherwise provided under the Plan.

"Calendar Year"
"Calendar Year" shall mean the 12-month period from January 1 thru December 31 of each year.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24 hour a day basis.

"Centers of Excellence"
"Centers of Excellence" shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Contract Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Contract Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Certified IDR Entity"
"Certified IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"Child"
"Child" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

"CHIP"
"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

"CHIPRA"
"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

"Chiropractic Care"

"Chiropractic Care" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

"Claim Determination Period"
"Claim Determination Period" shall mean each Calendar Year.

"Claimant"
"Claimant" shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

"Clean Claim"
A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

"CMS"
"CMS" shall mean Centers for Medicare and Medicaid Services.

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Coinsurance"
"Coinsurance" shall mean a cost sharing feature of many plans. It requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.

"Contract Administrator"
"Contract Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

"Copayment" or "Copay"
"Copayment" or "Copay" shall mean a dollar amount the Participant pays for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

"Covered Expense(s)"
"Covered Expense(s)" shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

"Covered Mental Health Service Providers"
"Covered Mental Health Service Providers" are Physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

"Custodial Care"
"Custodial Care" shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

"Deductible"
"Deductible" shall mean an amount of money that is paid once a Calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each Calendar year, a new Deductible amount is required.

"Dentist"
"Dentist" shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one who is divorced or Legally Separated from the Employee.
2. An Employee's Child who is less than 26 years of age; or
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers

above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Active duty members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."
The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

NOTE: Tax treatment for certain dependents. Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Service"
"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

"Disease"
"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"Drug"
"Drug" shall mean insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend "Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the United States Pharmacopeia, National Formulary or AMA Drug Evaluations published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Emergency"

"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition, the following:

2. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

3. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

"Employee"
"Employee" shall mean a person who is employed by the Employer on a full-time basis and regularly scheduled to work at least thirty (30) hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least thirty (30) hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Affordable Care Act (as amended).

The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

Administrative Period shall mean a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the

associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage.

Full-time Employee or Full-Time Employment shall mean with respect to a calendar month, an Employee who is employed an average of at least 30 hours of service per week with the Employer.

Hour of Service shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Measurement Period shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine your employment status for benefit purposes.

Initial Measurement Period - for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after 12 months consecutive months of service.

Standard Measurement Period - for Ongoing Employees, this Measurement Period will start on July 1 each year and will last for 12 consecutive months.

New Employee shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.

Non-variable Hour Employee shall mean an Employee reasonably expected at the time of hire to work 30 or more hours per week.

Ongoing Employee shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

Seasonal Employee shall mean an Employee who is hired into a position for which the customary annual employment is six months or less.

Stability Period shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is 3 months period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Variable Hour Employee shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

"Employer"
"Employer" is Imperial County Schools Voluntary Employees Benefits Association.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

"Essential Health Benefits"
"Essential Health Benefits" shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn

care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

"Exclusion"
"Exclusion" shall mean conditions or services that this Plan does not cover.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

"Family Unit"
"Family Unit" shall mean the Employee, his or her spouse and Children.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean a Leave of Absence, which the Employer is required to extend to an Employee under the provisions of the FMLA.

"GINA"
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

"Habilitation/Habilitative Services"
"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

"Health Breach Notification Rule"
"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"Health Maintenance Organization (HMO)"
"Health Maintenance Organization (HMO)" shall mean an organization that provides health coverage with providers under contract. Under an HMO plan the Participant will receive most or all of his/her health care from a network provider. HMOs require that the Participant select a primary care physician (PCP) who is responsible for managing and coordinating all the Participant's health care.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:

a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
b. It has a full time administrator;
c. It maintains written records of services provided to the patient;
d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
e. Its Employees are bonded and it provides malpractice insurance.

"Hospital"
"Hospital" shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24 hour a day nursing service by registered nurses;
4. It is duly licensed as a Hospital, except that this requirement will not apply in the case of a State tax supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"HRSA"
"HRSA" shall mean Health Resources and Services Administration.

"Illness"
"Illness" shall have the meaning set forth in the definition of "Disease."

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean any services, supplies, or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"
"Incurred" shall mean that a Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Independent Freestanding Emergency Department"
"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

"Injury"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or

profit.

"Inpatient"
"Inpatient" shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

"Institution"
"Institution" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Intensive Outpatient Services"
"Intensive Outpatient Services" shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment."

"Late Enrollee"
"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

"Leave of Absence"
"Leave of Absence" shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

"Legal Separation" and/or "Legally Separated"
"Legal Separation" and/or "Legally Separated" shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

"Mastectomy"
"Mastectomy" shall mean the surgical removal of all or part of a breast.

"Maximum Amount" or "Maximum Allowable Charge"
The "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or

- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

"Medical Child Support Order"
"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical Child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medically Necessary"
"Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Sickness or Injury without adversely affecting the Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not

"Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

"Medically Necessary Leave of Absence"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational Institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"Medical Record Review"
"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the Medical Record Review and audit results.

"Medicare"
"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or Substance Use Disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

1. The financial requirements applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
2. There are no separate cost sharing requirements that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
3. The treatment limitations applicable to such mental health or Substance Use Disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage).
4. There are no separate treatment limitations that are applicable only with respect to mental health or Substance Use Disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

"Mental or Nervous Disorder"
"Mental or Nervous Disorder" shall mean any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

"Network"
"Network" or "In-Network" shall mean the facilities, Providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network's Providers have agreed to accept assignment of benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.

"No-Fault Auto Insurance"
"No-Fault Auto Insurance" is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

"Non-Network" or "Out-of-Network"
"Non-Network" or "Out-of-Network" shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.

"Non-Occupational Injury"
"Non-Occupational Injury" shall have the meaning set forth in the definition of "Injury."

"Open Enrollment Period"
"Open Enrollment Period" shall mean the month of September in each Plan Year.

"Other Plan"
"Other Plan" shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

"Outpatient"
"Outpatient" shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

"Partial Hospitalization"
"Partial Hospitalization" shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

"Participant"
"Participant" shall mean any Employee or Dependent or retiree who is eligible for benefits under the Plan.

"Participating Health Care Facility"
"Participating Health Care Facility" shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"Patient Protection and Affordable Care Act (PPACA)"
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Preferred Provider Organization (PPO)"
"Preferred Provider Organization (PPO)" shall mean an organization that contracts with a network of providers from which the health plan Participant can choose. Participants do not need to select a primary care physician (PCP) and do not need referrals to see other providers in the network.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

This Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:

http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/coverage/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer at (ph) 760-335-5200.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Primary Care Physician (PCP)"
"Primary Care Physician (PCP)" shall mean family practitioners, general practitioners, internists, OB/GYNs, pediatricians, and office-based nurse practitioners and physician's assistants. All other Physicians are considered specialists.

"Provider"
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

"Qualifying Payment Amount"
"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Recognized Amount"
"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

"Rehabilitation"
"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury, Illness, or

Disease to as normal a condition as possible.

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Residential Treatment Facility"
"Residential Treatment Facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

"Sickness"
"Sickness" shall have the meaning set forth in the definition of "Disease."

"Sterilization"
"Sterilization" shall mean sterilization operation.

"Substance Abuse" and/or "Substance Use Disorder"
"Substance Abuse" and/or "Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.
The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse Treatment Center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic

and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation;

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation;

Alcohol. That arise from a Participant taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment;

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise;

Confined Persons. That are for services, supplies, and/or treatment of any Participant that Incurred while confined and/or arising from confinement in a prison, jail or other penal Institution;

Cosmetic Surgery. That Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9);

Custodial Care. That do not restore health, unless specifically mentioned otherwise;

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational;

Family Member. That are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law";

Foreign Travel. That are received outside of the United States if travel is for the sole purpose of obtaining medical services;

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for

the Participant to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare;

Government-Operated Facilities.

1. That are furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments; and
2. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law;

Illegal Acts. That arise from or are caused during the commission of any illegal act for which the participant could be incarcerated for any period of time. It is not necessary for an arrest to occur, charges to be filed, incarceration to occur, or a conviction to be had for this exclusion to apply. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness resulting from that Participant's voluntary taking of or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);

Incurred by Other Persons. For expenses actually Incurred by other persons;

Medical Necessity. That are not Medically Necessary;

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law;

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator;

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent;

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services;

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription Drug must be covered under Preventive Care, subject to the Affordable Care Act;

Not Acceptable. That are not accepted as standard practice by the AMA, ADA, or the Food and Drug

Administration;

Not Actually Rendered. That are not actually rendered;

Not Specifically Covered. That are not specifically covered under this Plan;

Occupational. For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational Injury medical coverage is available or would have been available had the participant sought to obtain it in accordance with applicable rules and/or procedures;

Postage, Shipping, Handling Charges, Etc. For any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator; including interest or financing charges;

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice;

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law;

Provider Error. That are required as a result of unreasonable Provider error;

Subrogation, Reimbursement, and/or Third Party Responsibility. That are of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions;

Unreasonable. That are not "Reasonable" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es);

Vehicle Accident. For treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt; and

War. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a medical condition.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
The following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance
If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Claim Determination Period
"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits

A. Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
2. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

B. Order of Benefit Determination

For the purposes of the provision entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan.

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent.
3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
    a. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

    Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
5. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information
The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment
A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay an amount pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over
An active Employee and his or her spouse (ages sixty-five (65) and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits
To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan
If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

    a. Notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
    b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
    c. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Contract Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Contract Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator
The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Contract Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the Employer.

Summary of Material Reduction (SMR)
A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The sixty (60) day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Summary of Material Modification (SMM)
A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred and ten (210) days after the close of the Plan Year in which the changes became effective.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

Health Claims
All claims and questions regarding health claims should be directed to the Contract Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Contract Administrator; provided, however, that the Contract Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Participant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post service. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Participant's medical condition,

would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    a. The Plan determines that the course of treatment should be reduced or terminated; or
    b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

    If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service health claims must be filed with the Contract Administrator within three hundred and sixty-five (365) days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within forty-five (45) days (48 hours in the case of Pre-service urgent care claims) from receipt by the Participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

a. If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.
b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than twenty-four (24) hours after receipt of the claim.
c. The Participant will be notified of a determination of benefits as soon as possible, but not later than forty-eight (48) hours, taking into account the medical exigencies, after the earliest of:
    i. The Plan's receipt of the specified information; or
    ii. The end of the period afforded the Participant to provide the information.
d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:

a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the Participant makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type

of claim (either as a pre-service non-urgent claim or a post-service claim).

d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

i.	Notification to Participant	thirty (30) days
ii.	Notification of Adverse Benefit Determination on appeal	thirty (30) days

4. Post-service Claims:

   a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
   b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

5. Extensions
   a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   b. ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   c. iii. Extensions – Post-service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three (3) days), containing the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA

following an Adverse Benefit Determination on final review.;

6. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request and
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Participants at least one hundred and eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice
8. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Contract Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and
9. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable

opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal
The Participant must file the appeal in writing (although oral appeals are permitted for pre service urgent care claims) within one hundred and eighty (180) days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

Delta Health Systems
3244 Brookside Road, suite 200
Stockton, CA 95219
Phone: 1-800-422-6099
Fax: 209-474-5407

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Delta Health Systems
3244 Brookside Road, suite 200
Stockton, CA 95219
Phone: 1-800-422-6099
Fax: 209-474-5407

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Participant;
2. The Employee/Participant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the appeal.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan's review procedures and the time limits applicable to the procedures;
7. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
8. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such

access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process
The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

    a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
    b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the

information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Appointment of Authorized Representative
A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments
For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical

Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Participant or Dependent on whose behalf such payment was made.

A Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, current ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant, Provider or other person or entity to enforce the provisions of this section, then that Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Participants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Participant or by any of his covered Dependents if such payment is made with respect to the Participant or any person covered or asserting coverage as a Dependent of the Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Participant for any outstanding amount(s).

Medicaid Coverage
A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be

subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A Claimant cannot bring any legal action against the Plan to recover reimbursement until 90 days after the Claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the Claimant's claim have been completed. If the Claimant wants to bring a legal action against the Plan, he or she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he or she loses any rights to bring such an action against the Plan. A Claimant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within three (3) years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

Claim Audit Review Program

The Claim Audit Review Program is designed to reward Employees for identifying and recovering erroneous charges on bills for medical services and supplies furnished to Claimants in the following circumstances:

1. When a Claimant independently identifies eligible overpayments for services, supplies and treatments not rendered or received the Claimant will be awarded ten percent (10%) of the recovered amount up to a $10,000 maximum on claims the Claimant reports to the Plan Administrator that are successfully recovered by the Plan.
2. The Plan Administrator will assist the Claimant with the determination of an eligible overpayment and will pursue the collection of the overpayment amount.
3. A final determination letter will be sent to the Claimant after the status of the audit has been completed. The Plan Administrator shall make the final determination regarding all qualifications for eligible overpayment and awarded amounts.

If a Participant audits any Physician, Hospital, or laboratory bill and discovers an error which results in savings to the Plan, the Participant shall share equally in the savings, not to exceed a maximum payment of $500. Errors already detected and corrected by the Third Party Administrators are not included.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage
The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated;
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date;
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. The last day of the month in which the termination of employment occurs;
6. The last day of the month following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period; or
7. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Retiree Coverage
The coverage of any Retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of death of the covered Retiree;
3. The date of the expiration of the last period for which the Retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing; or
4. The date the covered Retiree becomes eligible for Medicare coverage or becomes eligible for coverage under another Employer's health plan.

Termination Dates of Dependent Coverage
The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age twenty-six (26) or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such inability;
    b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
    c. Upon the Child's no longer being dependent on the Employee for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, other than a Dependent Child as defined herein, except as may be provided for in other areas of this section or within this document;
7. The last day of the month in which such person ceases to be a Dependent Child, as defined here, except as may be provided for in other areas of this section or within this document;
8. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the

calendar month as of which coverage is no longer required under the terms of the order or this Plan.

9. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Retirees & Surviving Spouses

Retirees

An Employee who retires from active service from a participating entity may elect to have continued coverage under the Plan's Comprehensive Option or Basic Option. Extended coverage may also include the retiring Employee's spouse and children who meet the Dependent eligibility criteria.

An eligible retired Employee (or the spouse of such a retiree) includes a person age 65 or older who is enrolled in or eligible for Medicare coverage. Plan benefits will be determined as though the retiree (or the retiree's spouse) were enrolled for all Medicare coverages for which the person is eligible.

Election for continued coverage must be made within thirty-one (31) days of Employee's loss of coverage as an active Employee. Except as required by law, if a retiree does not make a timely election he may be denied further opportunity to do so.

Cost of Coverage

A retiree will be required to contribute to the Plan at rates determined by the Plan Sponsor. Such rates may be subject to change.

Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants.

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire

A Variable Hour Employee who is terminated and rehired will be treated as an Ongoing Employee upon rehire only if the Employee break in service did not exceed 13 weeks.

Upon return, coverage will be effective immediately, so long as all other eligibility criteria are satisfied.

For an approved Leave of Absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved Leave of Absence, an Employee will be treated as an Ongoing Employee, even if the Employee's absence was longer than 13 weeks.

CONTINUATION OF COVERAGE

Continuation During Family and Medical Leave Act (FMLA) Leave
The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care with the eligible employee(s).
- To bond with a child (leave must be taken within 1 year of the child's birth or placement) with the eligible employee(s).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

Spouses employed by the same employer are jointly entitled to a combined total of 12 workweeks of FMLA leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care or placement for adoption or foster care must conclude within 12 months of the birth or placement.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must meet all of the following requirements:

- Have worked for the employer for at least 12 months.
- Have at least 1,250 hours of service in the 12 months before taking leave.*

- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
https://www.dol.gov/whd/
U.S. Department of Labor Wage and Hour Division
WH1420a - REV 04/16

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to twenty-four (24) months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless

of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction
The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, certain Participants and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage
"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events
A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;

3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or Legally Separated from his or her spouse.

Dependent children will become Qualified Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
48. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in the loss of coverage for any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary, with the bankruptcy being deemed to be the Qualifying Event. The retired Employee's Dependent(s) (if applicable) will also become Qualified Beneficiaries if the bankruptcy (Qualifying Event) results in a loss of their coverage under the Plan.

Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events
Each covered Employee or Qualified Participant is responsible for providing the COBRA Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former Employee) from his or her spouse;
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a
3. Dependent Child under the terms of the Plan;
4. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Participant has become entitled to COBRA Continuation Coverage with a maximum duration of eighteen (18) (or twenty- nine (29)) months;
5. **Notice Regarding Disability:** Notice that a Qualified Participant entitled to receive Continuation Coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first sixty (60) days of Continuation Coverage; and
6. **Notice Regarding End of Disability:** Notice that a Qualified Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Notification must be received by the COBRA Administrator, who is:

Infinisource
P.O. Box 949/ 15 East Washington Street
Coldwater, MI 49036
Phone: 1-800-594-6957
Fax: 517-279-9420
Email/Website: crmail@infinisource.com (general inquiries) or (electronically) www.infnisource.com

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for providing the notice
For Qualifying Events described above, the notice must be furnished by the date that is sixty (60) days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

For the disability determination described above, the notice must be furnished by the date that is sixty (60) days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be furnished before the end of the first eighteen (18) months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is thirty (30) days after the later of:

1. The date of the final determination by the SSA that the Qualified Participant is no longer disabled; or
2. The date on which the Qualified Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial eighteen (18)-month COBRA coverage period.

Who Can Provide the Notice
Any individual who is the covered Employee (or former Employee), a Qualified Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee)

or Qualified Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Participants with respect to the Qualifying Event.

Required Contents of the Notice
The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
    a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
    b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
    c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
    d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
    e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
    f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within thirty (30) days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within fourteen (14) days of receiving the notice of the Qualifying Event. The individual then has sixty (60) days in which to elect COBRA Continuation Coverage. The sixty (60) day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Duration of COBRA Continuation Coverage
The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Dependent of the retiree ends on the earlier of the Qualified Beneficiary’s death or 36 months after the death of the retiree.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee’s (or former Employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child’s losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the covered Employee’s hours of employment, and the covered Employee became entitled to Medicare benefits less than eighteen

(18) months before the Qualifying Event, COBRA Continuation Coverage for Qualified Participants other than the covered Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of eighteen (18) months. There are two (2) ways in which this eighteen (18) month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage
If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the COBRA Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional eleven (11) months of COBRA Continuation Coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA Continuation Coverage and must last at least until the end of the eighteen (18) month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage
If an Employee's family experiences another Qualifying Event while receiving eighteen (18) months of COBRA Continuation Coverage, the spouse and Dependent children in the family can get up to eighteen (18) additional months of COBRA Continuation Coverage, for a maximum of thirty-six (36) months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent children receiving COBRA Continuation Coverage if the covered Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of COBRA Continuation Coverage
COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of eighteen (18) months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of thirty-six (36) months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage may conclude prior to the latest possible date if the Employer ceases to provide a group health plan to any Employee; the Qualified Beneficiary fails to make timely payment of any required contributions or premium; the Qualified Beneficiary gains coverage under another group health plan (as an Employee or otherwise) or becomes entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); and/or any other event occurs which enables the Plan Administrator to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary and/or their Dependent). COBRA Continuation Coverage shall be extended to the first day of the month thirty (30) days (or more) subsequent to the date upon which the SSA determined that the Qualified Beneficiary is no longer disabled.

Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within forty-five (45) days. Payments then are due on the first day of each month to continue

coverage for that month. If a payment is not received within thirty (30) days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Trade Reform Act of 2002 and Trade Preferences Extension Act of 2015
The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six (6) months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or if they have any questions they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the COBRA Administrator, who is:

Infinisource
P.O. Box 949/ 15 East Washington Street
Coldwater, MI 49036
Phone: 1- 800-594-6957
Fax: 517-279-9420
Email/Website: crmail@infinisource.com (general inquiries) or (electronically) www.infnisource.com

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses
Important information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

MISCELLANEOUS PROVISIONS

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA") and the laws of the State of California. The Plan is funded with Employee and/or Employer contributions.

Clerical Error/Delay
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

Statements
All statements made by the Company or by a Participant will, in the absence of fraud, be considered

representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Binding Arbitration

***Note**: You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be

conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA, and any other applicable State law(s).

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling the Employer.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services,

Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.

3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
6. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
7. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Compliance Coordinator Contact Information:
Delta Health Systems
3244 Brookside Road, Ste 200
Stockton, CA 95219-2381
Phone: 1-800-422-6099
Fax: 209-474-5407

Website: www.deltahealthsystems.com

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Director of Employee Benefits.
        iii. Employee Benefits Department employees.
        iv. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan,

but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance
In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

IMPORTANT NUMBERS AND WEB SITE ADDRESSES

For preauthorization, forms, claims, questions or provider directories, refer to the information below.

Benefit Option	Contact Name and Information
Medical Network ***All locations*** ▪ Finding In-Network Providers ▪ Preauthorization	**Anthem Blue Cross PPO (Prudent Buyer)** www.deltahealthsystems.com 1-800-274-7767
Utilization Management Program Pre-admission and review requirements, etc.	**Anthem Blue Cross** 1-800-274-7767
Delta TeamCare Health Management Program A program to assist patients with complex or chronic medical conditions. Delta provides employees with a combination of patient advocacy, self-care education and one-on-one support by experienced health care professionals	**Disease Management** 1-866-440-4429 Nurses are available Monday – Thursday, 8:30am to 9:00pm EST and Friday, 8:30am to 7:00pm EST **Delta TeamCare Health Coaching** 1-866-274-0032
Contract Administration for Medical ONLY Including all: ▪ Claims Processing ▪ Eligibility Review ▪ Benefit Coverage ▪ Treatment Procedures **IMPORTANT:** For Information related to ANY of these areas for **Mental Health and Substance Use Disorder Benefits** see information below.	**Delta Health Systems** 1-866-691-2443 www.deltahealthsystems.com
Employee Assistance Program An EAP counselor is available 24 hours a day, 7 days a week for emergency and urgent assistance. To schedule an appointment, receive a community referral, or for inquiries our office is open 7:30 am to 6:30 pm PST.	**Beacon** 1-866-533-4278
Mental Health and Substance Use Disorder Including all: ▪ Claims Processing ▪ Eligibility Review ▪ Benefit Coverage ▪ Treatment Procedures	**Beacon** 1-866-533-4278
Prescription Benefits Retail and Mail Order	**Rx Benefits,** (800) 334-8134, RxHelp@rxbenefits.com
Benefit Consultants	**HUB International Insurance Services Inc.** 9985 Scranton Rd., Ste. 100 San Diego, CA 92121 Phone: (800) 633-2683

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